Health plan officials complain about a double whammy: low rates and high costs. Are hospital- and community health center-based plans going to be the only ones left?

Bailing Out of Medicaid Managed Care Programs

BY PETER WEHRWEIN

Two years ago, Medicaid managed care looked mighty tempting to Jeff D. Emerson, the CEO of NYLCare Health Plans of the Mid-Atlantic. Other plans seemed to be doing OK enrolling Medicaid beneficiaries as members. And there was a tantalizing number of covered lives at stake--over a million in his company's prime stomping ground of Maryland, Virginia and Washington, D.C. So Emerson geared up for a big Medicaid managed care push, spending about $500,000 in the process.

Then came Maryland's fine print--and Emerson's ire. "The constraints they were proposing to impose on plans were unconscionable," says Emerson. He was particularly incensed at Maryland's requirement that new members be seen by a primary care physician within 30 days of joining a health plan or the plan would be docked 10 percent of its capitation payment.

Maryland Medicaid officials say the requirement was for 90 days, not 30, and that participating plans only had to notify new members of a schedule of covered wellness services. Even if that were so, Emerson says, he was bothered by what he considered a double standard.

"The state of Maryland, the largest employer in the state and the largest payer for health care, doesn't make health plans that cover state employees do that," he says. "But it does for Medicaid enrollees. In other words, the state has a higher standard for Medicaid enrollees than its own employees. That makes no sense at all to me." Toss in low reimbursement rates in Virginia and too many competing plans in the D.C. market, and Emerson ended up saying thanks, but no thanks, to any Medicaid business, notwithstanding the company's $500,000 investment.

"I don't think rates are high enough to warrant the risk," he says, "And it is a political quagmire: It seems every time you decide to take Medicaid, you are setting yourself up to get flogged by politicians. It's not a winning combination."

To which a sizable chorus of health plan executives these days is whispering, "Amen."

The exodus

In theory, Medicaid managed care was a win-win, and then win-again, situation. For state officials and politicians, it was to be the antidote to the feverish rise in their Medicaid costs and resulting havoc to budgets. For the roughly 30 million beneficiaries, Medicaid managed care was supposed to mean new access to mainstream providers and, in many states, an end to the de facto health-care segregation caused by low Medicaid reimbursement rates, especially for physicians. And for health plans, Medicaid managed care would mean 30 million covered lives and a whole lot of new business.

On the bright side, Medicaid managed care enrollment has soared since 1993, when the federal government started to promote and grant the waivers necessary for state programs to enroll beneficiaries in managed care plans. In 1991, 9.5 percent of the country's 28 million Medicaid beneficiaries were in managed care plans. Last year, almost half--47.8 percent--of 32 million beneficiaries were in managed care.

Physicians such as Howard Stinson, D.O., of Miami, say managed care has, by and large, lived up to its billing as a

vehicle for providing preventive health services, including prenatal care, vaccinations and screening tests for the poor women and children who dominate the program in south Florida and elsewhere. Moreover, access to care has been reciprocated by a refreshing attitude on the part of enrollees. "In the last couple of years, I have seen a change in the Medicaid population here in south Florida," says Stinson. "People are taking responsibility for their medical needs. I don't find them any less good about keeping appointments than commercial members." And health plan executives like Michael McCallister, a senior vice president for Humana Inc., evince confidence about managing Medicaid costs. "A network is a network. You can run a variety of products through it as long as you have a solid infrastructure," says McCallister, whose company became one of the biggest Medicaid managed care companies in the country last fall after its acquisition of Physician Corp. of America.

But that's only the bright side of the picture. The early, infamous years of Tenncare, Tennessee's Medicaid managed care program, showed how managed Medicaid can be fertile ground for all kinds of sleazy enrollment practices and fly-by-night operators. Now a recent spate of headlines has several prominent health plans jumping ship and getting out of Medicaid programs.

Eight plans, including Aetna U.S. Healthcare, have dropped out of New York State's ambitious program to shift 2.2 million of its Medicaid beneficiaries to managed care plans. Troubled Oxford Health Plans announced in February that it would no longer participate in programs in New Jersey and its home state, Connecticut, and New York officials are nervous that Oxford will bow out in their state as well. United Healthcare Corp., in Ohio's Medicaid program for over a decade, dropped out completely last year.

And it is not just the for-profit HMOs that are finding that they can't--or don't want to--make a go of Medicaid. In February, Blue Cross and Blue Shield of Massachusetts announced it was dropping out of the Bay State's Medicaid program, even though Massachusetts requires health plans that want to compete for lucrative state employee contracts to have a Medicaid program. The company says it lost $14 million during the past two years of its Medicaid contract and has projected an $8 million loss this year.

Of bum raps and rates

Why the exodus? There are the political bumps and bruises mentioned by Emerson. Physician attitudes can also be a problem. Richard Hannon, a senior vice president for Blue Cross and Blue Shield of Arizona in Phoenix, says that his company decided not to renew its Medicaid contract last year partly because of growing resentment on the part of some physicians in its network. Medicaid--which in Arizona is called the Arizona Health Care Cost Containment System (AHCCCS) and is pronounced "access"--necessarily involves some tighter controls, according to Hannon.

"They didn't want us to act like an AHCCCS company. They wanted us to act like what they were used to, a commercial HMO."

In Massachusetts, Blue Cross and Blue Shield considered a separate provider network and medical management approach. The idea was dropped when an analysis showed the plan would still lose money. In a written response to written questions from Managed Care, company officials said, "[The company] has treated Medicaid as an HMO Blue 'account' as opposed to a unique product," and gave that as one reason for--as they delicately put it--the "unfavorable status" of its Medicaid business.

The other reason cited was low state Medicaid rates, which certainly conforms to one of the most popular versions of the prevailing wisdom, which goes something like this: After luring mainstream health plans into their Medicaid programs with relatively generous rates, state officials saw--or thought they saw--health plans gorging on taxpayer-provided Medicaid dollars, and set about to trim the rates. (A variation on this theme is that in New York and some

other states, the rates were too low to begin with.)

Given the razor-thin margins in managed care these days, state efforts to squeeze Medicaid rates strike many health plan executives as adding insult to their already injured bottom lines. "For years, they have tried to control their Medicaid budgets any way they could and now they are doing it with the health plans," comments Helen L. Smits, M.D., president and medical director of HealthRight Inc., a Medicaid managed care-only plan in Meriden, Conn. "I think it is really frightening because if it is like this when times are good--when employment is high, when there are low numbers on the welfare rolls, when taxes are coming into state coffers--then what is it going to be like when times get bad?" In Connecticut, says Smits, the basic per-member, per-month Medicaid rate has slid from $150 to $140 the last couple of years, while the prevailing commercial rate now sits at roughly $170.

Usually it has taken some kind of political kick in the pants, but some states have come up with the obvious solution: They've raised their Medicaid managed care rates. So, for example, in New York, after initially promulgating rates that provoked cries of impoverishment from the health plans, the legislature asked for an actuarial second opinion, which last year resulted in add-ons equaling a 12-percent across-the-board increase, according to Frances Tarlton, a state Health Department spokeswoman. A 4-percent increase in rates will take effect this month, said Tarlton, and as the mandatory enrollment gets phased in, plans will get an additional 5-percent rate hike.

Familiar scenario

For anyone who has spent any amount of time around a statehouse--especially one that featured those Kabuki-style political struggles over hospital reimbursement rates--this kind of back-and-forth over Medicaid managed care rates will seem all too familiar. What is more, says Paul Ginsburg, the entire situation that the states and the health plans now find themselves in "was not entirely unexpected." Ginsburg, who is president of the Center for Health System Change, a Washington, D.C.-based research center, notes that when the states started getting into managed care, they didn't have much to go on. They based their rates on their fee-for-service experience, minus 5 to 10 percent. They had little basis for predicting how costs would compare with those rates. But those rates attracted many plans, including mainstream plans. Then, when state officials perceived that the Medicaid business was more profitable than expected, they lowered rates. "While this might strike some as in the industry as sinister, it really was a means of coping with uncertainty due to lack of information," says Ginsburg.

Even now, six years after the Health Care Financing Administration launched the Medicaid managed care push by granting states waivers, "Whether rates are really accurate is in dispute," says Robert Hurley, a leading authority on Medicaid at the Medical College of Virginia in Richmond. Indeed, he adds, initially some plans might very well have benefited from favorable selection: It has been shown over and over that when enrollment in managed care is voluntary, the healthiest, thus the least costly, people join. Aggressive marketing tactics, often widely condemned as unethical, can accentuate this tendency. Then, as enrollment becomes mandatory, sicker people join health plans. Costs go up and rates that once looked generous (overly so, if you are a Medicaid official) become inadequate.

With Medicaid, it is often not a question of people choosing for themselves, but what categories of beneficiaries state officials decide to usher into managed care. In Connecticut, for example, when the Medicaid managed care program got started in 1995, it did not include pregnant women in a "healthy start" program, notes Smits. It also did not include children in state custody, who are often kids coming from the direst of circumstances, scarred by abuse and the effects of familial drug and alcohol addictions.

When plans seemed to rake in handsome profits, the state simultaneously cut the rates and added the healthy start mothers and kids in state custody to the Medicaid managed care program, according to Smits. For HealthRight, this meant the number of covered deliveries skyrocketed in just a few months. With deliveries costing $5,000 to

$10,000, and the annual revenue from the $140 per-member, per-month rate totaling $1,680, Smits says HealthRight loses money on every delivery, not just the complicated ones. "The women in my plan are having four times as many babies as the women in a commercial population," she says. "The babies are the biggest difference between my population and a commercial population--just the sheer number of babies."

Survival of the fittest

But how big a problem is it really that some health plans are leaving Medicaid managed care? Overall, enrollment seems to be growing vigorously, though a cautionary note is warranted: The most recent HCFA tally dates back to June 30, 1997, and therefore wouldn't reflect recent defections. One attitude to take is that if Aetna U.S. Healthcare and other departing health plans can't stand the heat, then let them get out of the Medicaid kitchen. Ginsburg says that state Medicaid officials shouldn't be too quick to push the panic button. "Just because one the first plans bailed out, I won't take it as a sign that I am doing the wrong thing." That seems to be the current outlook of New York officials. Tarlton, the New York Health Department spokeswoman, says the state certainly doesn't want Oxford to leave New York's Medicaid program, but also notes that in New York City, "There are many other plans participating, and new plans coming in." Translation: There are plenty of alternatives.

Even Smits, who thinks Connecticut officials should take Oxford's departure very seriously, sees some advantage to a Medicaid shakeout. For one thing, HealthFirst and remaining plans could achieve some cost-effective economies of scale. "One of the things we want to do is get big, fast," notes Smits, who, until state health officials nixed the deal, hoped to add Oxford's 33,000 Medicaid lives to HealthFirst's 30,000, doubling its enrollment in one fell swoop. Carol Tobias, a Medicaid researcher at Boston University's School of Public Health, says one reason Blue Cross and Blue Shield of Massachusetts fared so badly with Medicaid managed care is that the company, with 41,000 members out of a total enrollment of 479,000, "just didn't have the volume."

Robert Master, M.D., thinks one reason health plans are getting out of Medicaid is that some didn't belong there in the first place. Master is chief medical officer of Neighborhood Health Plan, a community health center-based health plan in Boston that has been remarkably successful, financially and otherwise. Prior to his current position, Master won accolades as the founder of a small, Boston-based health plan tailored to people with chronic diseases and disabilities. Master calls commercial health plans "the vanilla plans" and he says that when it comes to the Medicaid population, "They are square pegs in round holes." Successful Medicaid managed care requires intimate knowledge of needs and costs, especially of the disabled, says Master, noting that the care of a single person with a spinal cord injury can easily cost three times the $500 per-member, per-month rate commonly paid by the state for people who are classified as disabled. With AIDS, the costs are even higher.

Ahead of the learning curve

Master, whose experience with Boston's community health centers goes back 25 years, says plans like the one he started and Neighborhood Health Plan stand to be more successful with Medicaid managed care because they know what they are managing. "We are 25 years ahead on the learning curve. I don't think you can overestimate the importance of that. This is a world that we have lived in."

Yet there's the rub. While the expertise and savvy that inner-city hospitals and health centers have with the Medicaid population cannot be denied, the scenario of Medicaid managed care falling exclusively into the hands of worldly wise Medicaid pros is not one that many would applaud. Hurley, at the Medical College of Virginia, worries about Medicaid managed care contracts going by default to neophyte hospital- and community health center-based programs "with no history, no experience, no infrastructure." (He made a point of excepting Neighborhood Health Plan, which he described as a "real HMO.") Besides courting management and cost disasters, such a dependence

would also "formalize a separate delivery system" for Medicaid recipients, he says--just the kind of thing that health policy makers hoped Medicaid managed care would dismantle.

Perhaps the pendulum will swing back and health plans will be enticed back to the Medicaid program, but in the meantime, says Hurley, "you have to be concerned about who is going to be left standing."

Peter Wehrwein is a frequent contributor to Managed Care.

Medicaid matters

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As its ambitious plans for national-level health care reform started to wither and die, the Clinton administration started to promote the Section 1115 waivers that allow states to place Medicaid beneficiaries in managed care plans. (The waivers are necessary because Medicaid is a federal-state program). Medicaid managed care enrollment has been soaring ever since. In 1991, only 9.5 percent of the country's 28 million Medicaid beneficiaries were in managed care plans. Last year, almost half--47.8 percent--of 32 million Medicaid beneficiaries were in managed care plans.